

Complex lives,
complex systems:
supporting 16 and 17-
year-olds experiencing
heightened risk and
need



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Introduction

The position of 16 and 17-year-olds across Scottish legislation, policy and practice varies and there are competing and cross-cutting definitions of childhood and adulthood ([Martin, 2024](#); [Scottish Government, 2023](#)). In some contexts, 16 and 17-year-olds are defined as children whilst in others they are defined as, and treated akin to, adults. Sometimes 16 and 17-year-olds are only treated as children when subject to referral or measures through the Children's Hearings System. Under the [United Nations Convention on the Rights of the Child](#), now incorporated into [Scots law](#); [Getting it Right for Every Child](#), Scotland's national practice model; [Children and Young People \(Scotland\) Act 2014](#); and the [national Child Protection guidance](#) (Scottish Government, 2023), 16 and 17-year-olds are recognised as children. The position of this group is receiving enhanced attention. For example - once fully commenced¹ - the [Children \(Care and Justice\) \(Scotland\) Act 2024](#) will go some way to bring consistency to the definition of a child as anyone under the age of 18 in children's hearings, criminal justice, and anti-social behaviour legislation but this will not apply across all pieces of legislation. Furthermore, the Scottish Mental Health Law Review recommended that "the Scottish Government should take forward detailed analysis of the implications of changes in age limits in the child welfare system for the interface with adult support and protection" ([Scott, 2022](#), p.625). The Scottish Government is also [consulting](#) on raising the legal minimum age of marriage from 16 to 18.

Varying definitions of a child can be appropriate in maximising the potential options for intervention, support and protections. However, this means that in situations where 16 and 17-year-olds face, make or take risks (for example, owing to abuse or neglect, exploitation, self-harm, absconding, coming into conflict with the law or causing harm to others) there are various processes and legal contexts that could be utilised by practitioners or multi-disciplinary teams to support assessment, planning and management of need and risk. These processes include Child Protection; Adult Support and Protection (ASP); referral to the Principal Reporter; use of mental health legislation; Care and Risk Management (CARM); or Multi-agency Public Protection (MAPPA) Proceduresⁱ. Although it is difficult to quantify the extent of this issue, practitioners have repeatedly faced challenges in identifying and determining which process(es) should be utilised, thus leading to complexities in terms of supports and interventions (Martin, 2024).

This resource has been developed to support practice and practitioners who face these challenges and in determining how to respond to complex circumstances experienced by 16 and 17-year-olds. The resource outlines the principles of good practice and what each of these different, complex systems and processes could offer specifically for 16 and 17-year-olds. The different processes and legal contexts are expanded upon in these short recordings and [slides](#). In addition, Appendix 1

¹ Commencement of the Act is being phased with many parts of the Act already live. Provisions in respect of the Children's Hearings System - including raising the age of referral to the Principal Reporter - are due to go live in 2027. You can find out more on the [CYCJ website](#).

contains various case study examples that illustrate which approaches could be used in practice and key considerations in determining how to respond, based upon the insights of practitioners who attended two multi-agency events. This resource aims to complement, but does not supersede national guidance or local policies and procedures, and should prove useful for practitioners in any agency tasked with responding to risk with 16 and 17-year-olds. Whichever process or approach is used, a high-quality, multi-agency assessment of need and risk should be completed and where required a robust and individualised plan developed to meet identified needs and address risks. Use of “the Act” relates to the specific legislation within that section of the resource rather than one particular Act.

Risks and needs amongst 16 and 17-year-olds

The short summary below highlights a number of issues that may be faced by 16 or 17-year-old children. Whilst these are not unique to this age group, and may be faced both those younger and older than this cohort, they are more prevalent in comparison to their peers and may require additional considerations given the particular legal and social status of the children in question.

- **Mental ill-health:** During late teenage years, mental health can decline and this can be the point of onset of serious mental illness. [A range of factors](#) can place stress on children's pre-existing resilience and coping strategies including transitions; increased use of online communities and social media; experiences of bullying, harassment and abusive behaviour; poverty; inequality; homelessness and abuse. This highlights the importance of considering the child's wider circumstances alongside any mental health concerns.
- **Neurodiversity:** Neurodevelopmental needs and are a group of conditions that manifest early in development – although may go undetected - and can produce impairments of personal, social, academic or occupational functioning. These can reach the threshold for diagnosis as a neurodevelopmental disorder. [Autistic Spectrum Disorder](#), for example, can contribute to children coming into conflict with the law, as can [Foetal Alcohol Spectrum Disorder](#). Without appropriate identification and support, longer-term problems can arise such as social exclusion or involvement in the justice system.
- **Poverty:** Whilst an issue across the Scottish population, poverty disproportionately impacts children, with an estimated [one in four children](#) across Scotland experiencing poverty. [Its impact is wide-ranging](#), with studies showing that there is a significant link to mental ill-health, exclusion from opportunities (including leisure and recreation, peer friendships and digital access), stigma and hampered educational attainment. Children who experience poverty are more likely to live in areas with higher levels of deprivation and are [disproportionately represented](#) amongst those who are referred to the Children's Hearings System, accommodated within secure care, or in contact with the justice system.
- **[Adverse childhood experiences \(ACEs\)](#):** ACEs are a group of ten circumstances that have to correlative with increased risk of problems and adverse outcomes such as health problems, involvement with the justice system and drug use. It is important, however, to note that exposure to ACEs alone does not ultimately lead to adverse outcomes or conflict with the law.
- **[Trauma](#):** Trauma is an event, series of events of set of circumstances that cause significant harm or distress and results in long-term impairment to a child's emotional, mental, physical or social wellbeing. These events may be

one-off incidents, or part of a wider pattern of abuse, for example. As a result of trauma, children may display anger, impulsivity, hyperarousal or have difficulty controlling their emotions. Involvement in the care and justice system is likely to be a traumatic experience for a child.

- **Housing:** Housing insecurity plays a role in [driving children into precarious and risky situations](#). This could include rough sleeping, temporary accommodation, 'sofa surfing' and living in overcrowded housing. The relationship between housing insecurity and adverse circumstances is extensive: it has been linked to increased involvement in crime, repeat offending, complex mental health issues, substance abuse and higher exposure to ACEs. Housing insecurity is particularly prevalent amongst those who have experience of care and is often [a significant factor in unsatisfactory transitions](#) from the care and justice system to the community.
- **Domestic abuse:** [Children who experience domestic abuse](#) do so at a particularly vulnerable point in their lives when they are still emotionally developing, and their brains are maturing. The abuse that children experience is no less severe than older victims. Children who cause harm within intimate partner relationships are often victims themselves through other circumstances such as exposure to violence and abuse in childhood; presence of community norms that support gendered violence; and extra-familial exploitation.
- **Self-harm:** Self-harm can involve a [range of deliberate acts that adversely affect the child's physical or psychological health](#). This may be done for a variety of reasons including to distract/relieve themselves from emotional or physical pain, to gain agency over their life, to communicate great distress to others. The [prevalence and impact of self-harm](#) by children are highest amongst those who are older.
- **Conflict with the law:** Behaviour that brings a child into conflict with the law is a typical feature of childhood, with convictions rates peaking around the age of 18. There has broadly been a reduction in episodes of harm amongst adolescents over the preceding decades, although [recent data](#) points to a small cohort of children who cause significant harm to others. The vast majority of children who come into conflict with the law do not continue to do so into adulthood.
- **Alcohol and substance use:** Experimenting with alcohol, drugs and substances are [common experiences](#) for adolescents as they grow up, drift from their immediate families and test boundaries. Adolescents commonly seek new experiences, with tendencies towards sensation-seeking, risk-taking and impulsivity. Peer pressure may also contribute towards a child experimenting with alcohol and drug use and this may lead them to conform to actions of their friends. Adolescence is a period marked by significant

physical and behavioural changes, which makes children and young people more susceptible to the lasting impact of substance use and the excessive consumption of alcohol on the brain and body.

- **Brain development:** Adolescence is the transition period between late childhood and adulthood, whereby children often seek new experiences, with tendencies towards sensation-seeking, risk-taking and impulsivity, often with little apparent regard for consequences. [Studies show](#) that the part of the brain that responds to rewards show an exaggerated response in adolescence, as well as a lower level of response to anticipatory rewards, a characteristic linked to increased risk-taking behaviours. Teenagers can of course make rational decisions, but this ability is impaired in more emotional/stressful situations whilst peer pressure can increase risky decision-making by 16 and 17-year-olds.
- **Exploitation:** Exploitation can take a range of forms including [Criminal Exploitation](#) or [Sexual Exploitation](#). Exploitation involves using an imbalance of power to entice a child into performing certain acts (e.g. criminal or sexual) in exchange for something a child needs or wants. This can often involve threats or violence to maintain a child's participation in such acts. Children are particularly vulnerable due to their age and stage of development, with poverty, homelessness, insecure immigration status and separation from protective factors such as friends and family particular risk factors.

Principles of good practice

- **Rights-based:** We all have a responsibility, individually and collectively, to protect vulnerable children, young people and adults within our communities. Children's unique developmental stage and rights must be recognised and upheld; children must not be treated as mini-adults. Each child's evolving capabilities must be understood in order to balance their right to protection and support with their growing level of autonomy ([UN Committee on the Rights of the Child, 2016](#); [Scottish Government, 2024](#)). Balancing the child's (at times competing) rights, and the rights of others can be challenging, particularly when working with this age group. Reflection upon these demands and dilemmas is essential in order to find a balanced and measured position. Of course, this may result in decisions being made that children and their families disagree with.
- **Participation of the child:** Seeking out and listening to the child's views is both essential to deliver rights-based practice, and in developing a better understanding of the child's circumstances. This may require identifying supportive adults to help the child to express their views. Children's views of their best interests and that of practitioners/multi-agency assessments do not always align. The child's views about what is best for them must be balanced with their rights to be protected by adults and professionals (Haydon, 2018; Martin, 2024). The success or otherwise of plans, approaches and interventions are often dependent on the quality of the relationship in securing higher levels of engagement, cooperation and - where necessary – compliance from children and their parents. Relationship based, trauma informed and system-informed practice is key.
- **GIRFEC/GIRFE:** Assessing the needs and risks experienced by children within their wider world, and planning for improving the wellbeing of children and their families should take place within a GIRFEC/child protection continuum in the first instance. The most appropriate approach or process for a child may shift as assessments progress or needs and risks change. All practitioners should have a baseline understanding of adolescent development, children rights and training in risk assessment and formulation.
- **Involving the right services, at the right time:** Holistic assessment and decision-making requires a multi-agency approach informed by the knowledge, skills and understanding across services. Where concerns involve a 16 and 17-year-old representatives from children and families **and** adult services should be involved, where appropriate, including in [Initial Referral Discussions](#) (or equivalent processes). If the harm involves someone over the age 16, ASP criteria should be considered in determining the suitability of ASP procedures. For 16 and 17-year-olds this might involve a wider range of partners such housing, health, addiction, training services and community-wide partners in keeping with a [contextual safeguarding](#) approach. This can

involve cross-border partners where a child is under the care of a local authority from outwith Scotland but the child resides in Scotland. The processes detailed throughout this document can apply and may involve varying roles and responsibilities between the child's home and the Scottish local authority. Partnership working can be supported by joint training; shared understanding of individual, organisational and collective roles and responsibilities; shared data; and building relationships.

- **Intersectionality:** It is rare that a child presents with just one need or risk, therefore understanding and addressing the interaction of these issues in an intersectional and holistic manner is important. How approaches will impact on cross-cutting vulnerabilities or protected characteristics such as race, gender or disability should also be considered.
- **Applying multiple approaches:** Different approaches can place differing duties upon particular agencies. Deciding which service will lead this work will depend on which approach is ultimately adopted. Simultaneously utilising the approaches detailed within this document is possible where this would benefit and best meet the needs, risks and vulnerabilities of the child. For example, it may be the case that both child protection processes **and** MAPPA are required in small number of cases. It is less likely that child protection and ASP are simultaneously employed however. The risks of creating further confusion amongst children and families who often find such processes alienating and confusing should be considered. Where used simultaneously the different purposes, implications, roles and responsibilities of each process and the professionals within these should be agreed and clearly explained to the child (and their family, where appropriate).
- **Transitions:** Moving from one stage of life to another, or leaving a particular setting can prove challenging. Differences exist in the way children and adult services operate (e.g. referral and eligibility criteria, thresholds and how these services are experienced by children and young people) (Martin, 2024). Clear planning and well-managed transitions; joined up working; moves between services being based on the needs, situation and readiness of the child rather than age; and the application of frameworks such as [ARC Scotland's Principles of Good Transitions](#) can be beneficial (Martin, 2024). Some of the processes detailed in this document can only apply until a child reaches the age of 18 however. This can inform decision making and even where the processes cannot apply post-18, the principles and approaches to working with children can be useful when working with young people and should be encouraged.
- **The role of parents:** Whilst parental rights cease when a child turns 16, parental responsibilities to provide guidance to their child remain in place to age 18. Parents can be a protective factor at some points and for some children, but on other occasions may make provision of appropriate support

more difficult (Martin, 2024). The best interests of the child should be a key factor in determining the extent to which parents and families are included within approaches and processes. The needs of parents and carers in their own right should also be considered.

- **Supporting the workforce:** Working with 16 and 17-year-olds can present distinct and unique practice challenges. These can be compounded within the wider context including of resource challenges, workforce crisis in some sectors, and enhanced levels of need and demand. Support to staff including training; opportunities to build confidence and experience; good quality, regular and protected time for case reflection and reflective supervision; and adopting a learning culture where children experience or cause harm is essential.

What can different processes offer?

The following section provides information on each of the processes that could be utilised when responding to risk amongst 16 and 17-year-olds. Content includes the nature of risk/concern the process can respond to; criteria including age limitations; links to the underpinning policy, legislation and guidance; and matters like consent and parental involvement. Frequently asked questions are also highlighted that will continue to be updated as this resource evolves and feedback is received.

Child Protection



Nature of risk/concern

Child Protection processes are designed to address risk in relation to abuse, neglect or other harms. This may involve inflicting harm or failing to act to prevent harm. Children may be harmed:

- at home;
- within a family or peer network;
- in care placements; institutions or community settings in the online and digital environment.

Those responsible may be unknown or familiar to the child, or in positions of trust. They may be family members. Some risks or harm may be related to wider contextual factors and/or due to the actions of the child themselves. This requires careful assessment considering and listening to the lived experience of the child, particularly when they are in the 16 and 17-year-old age group.

Age range

Child protection processes can apply pre-birth until the age of 18. In practice older children have historically been less likely to be involved in child protection processes. The new National Guidance and legislative shift in recent years towards considering children as under 18 – rather than merely those under 16 - is designed to help promote a shift in this practice culture and consider need and risk in a child protection context if required.

Child Protection processes do not apply post 18. However, young people may still benefit from support from services. In some areas **Vulnerable Young Person's Protocols** – sometimes known as **Young Person at Risk Protocols** - may extend beyond age 18. In addition, young people with [care experience](#) may receive support as part of **Continuing Care** and **Aftercare** arrangements which can offer additional support and protection to a young person after they turn 18. For the purpose of Children's Services Plans, a 'child' is a person under 18 years old or a care leaver aged 18-25 years old eligible to receive 'children's services'. Adult social work services may well also have a role in providing continuing support to a young person depending on their needs and eligibility for certain services.

Criteria/threshold

Risk of **significant harm** is the key criteria which demarcates the threshold for child protection referral and processes. However, significant harm is not defined in legislation but is a matter of multi-agency professional judgement and decision making based on the assessed evidence. Processes such as Interagency Referral Discussion (IRD), investigation, joint Investigative interviews utilising the new SCIM and emerging Bairns' Hoose approaches, and Child Protection Planning Meeting (CPPM), are the key process and forums where these decisions are made and plans developed to offer support and protection. In some areas of Scotland Contextual Safeguarding approaches are being developed as a child protection response to harm outwith the family and for older children at risk in community contexts.

Legislation/policy/guidance

[National Guidance for Child Protection in Scotland](#) 2021, updated 2023 includes a definition of a child up to 18. Legislation relevant to child protection is detailed within the National Guidance and can be found at: [Understanding Age in Child Protection Guidance and Adult Support and Protection legislation Guidance and Legislation table](#) which helpfully compares legislation across child protection and adult protection, particularly relevant for this transition phase of 16 and 17-year-olds.

Information sharing with parents/carers

For all 16 and 17-year-olds who are referred for child protection concerns, consideration should be given to sharing information with parents, carers, and/or other professionals to inform risk assessment and protection. Decisions on sharing information with or without permission for this age group are informed by the individual circumstances of the situation. Where a child does not consent to the

sharing of information this should be fully considered and the child should not be pressured to consent to their information being shared. However, there may be instances where it is lawful to share without consent when this is in the best interests of the child. The rationale for sharing or not sharing should be clearly recorded (for more information see [Scottish Government, 2022](#)).

Parents and carers, and children of sufficient age and understanding, should be given a written record of decisions taken about the outcome of an investigation, unless this is likely to place the child at risk of significant harm or impede any criminal investigation. Guidance about involving children and families in child protection processes are detailed in paragraphs 3.127-3.138 of the [National Child Protection Guidance](#), with paragraphs 3.133 and 3.135 particularly relevant.

Consent to referrals/within processes

Consent of the child is not required when making a referral about a person under 18 who may be at risk from abuse, neglect, exploitation or violence.

However, and especially with respect to older children, it will usually be appropriate to share that a referral is being made because of the concern you have for their safety. At times it may not be safe to share this if it is judged that to do so might increase the risk of harm to the child e.g., they will run away or be exposed to greater risk. A decision not to share should be clearly recorded.

Practitioners should presume that children have the capacity to form their own views; and make decisions based on those views. Where there is evidence to suggest that the child does not have this capacity, consent should be sought from the parent unless there are reasons not to do so. Rationale for decisions pertaining to consent should be clearly recorded. In general, it should be assumed that a child who is over the age of 12 years has reached the age where they have the necessary level of maturity to understand the full implications of information sharing, unless there is evidence to the contrary².

In respect of medical examinations, the [Age of Legal Capacity \(Scotland\) Act 1991](#) allows a child under the age of 16 to consent to any medical procedure or practice if in the opinion of the qualified medical practitioner the child can understand the nature and possible consequences of the proposed examination or procedure. Children who are assessed as having capacity to consent can withhold their consent to any part of the medical examination, 16 and 17-year-olds therefore are required to consent.

Consent from parents/carers is not usually sought for medical examinations. The procurator fiscal may, in certain circumstances, consider obtaining a warrant for the purposes of medical examinations. This is more likely to occur when the child has capacity issues. However, where a child has legal capacity to consent declines to do so, they will not seek a warrant.

² Evolving capacity applies to all children. When working with other children, there will be those under 12 who have the capacity and maturity to share a view on matters that affect them

FAQs

- *In what situations might child protection processes be helpful?*

In any situation where there are known or suspected risk of significant harm for 16–17-year-olds, then a referral to social work or police should trigger an inter-agency referral discussion. Core agencies (social work, police and health) will make an initial assessment of the risks and any action that is required to protect the child. The IRD should consider which processes are best able to address the risks and protect the child as appropriate.

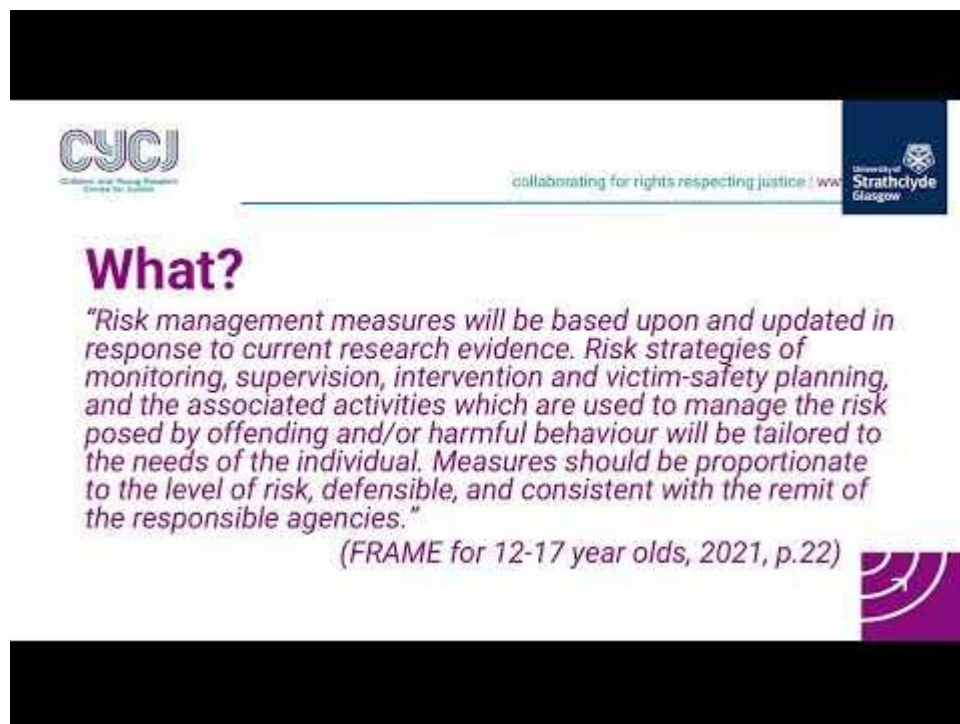
- *Should IRDs include reps from adult services when considering the needs and risks for 16 and 17-year-olds*

In many areas this happens and is considered positive practice, but there are variations across the country in how IRDs are conducted. On a case-by-case basis the need for adult services input and expertise should be considered, irrespective of whether local protocols recommend attendance or not. The views and opinion of adult services, and any relevant information they provide, should be fed into the IRD process if they are not in attendance themselves.

- *Does neglect still apply to 16 and 17-year-olds and if so what can be done to address neglect?*

Yes all children can experience neglect and criminal charges can be brought against adults for neglecting children of all ages. The full enactment of the Children (Care and Justice) (Scotland) Act 2024 will mean that 16 and 17-year-olds can be referred to the Children's Reporter on any ground-including those relating to care and protection. Children in this age group can also be subject to child protection measures in the same way as younger children and provided with accommodation under s.25 of the Children (Scotland) Act 1995 if found to be living in neglectful circumstances.

FRAME for 12-17-year-olds (CARM)



Nature of risk/concern

CARM protocols relate to episodes of physical or sexual violence – or the threat of such acts – displayed by the child towards another person or persons. This could include Harmful Sexual Behaviour, assaults, or the use of weapons. It could also be employed for those children who have not completed such acts, but who are deemed to pose a heightened risk of doing so. A robust formulation of risk is necessary in all instances (for more information see [CYCJ, 2025](#)).

Age range

CARM protocols can be utilised with children aged 12 until their 18th birthday. Children under the age of 12 whose behaviour poses a significant risk to others should be supported through Child Protection protocols.

In those cases where the child has been convicted of a relevant offence, the child may be managed through **Multi-Agency Public Protection Arrangements (MAPPA)** before they turn 18. In all other cases, CARM procedures would come to an end upon the child's 18th birthday, however there is nothing to prevent local authorities and partners from convening similar multi-agency meetings in order to consider the risks associated with the young person.

Criteria/threshold

For CARM to be applied, a child must be deemed to pose a risk of serious harm which is defined as:

“the likelihood of harmful behaviour of a violent or sexual nature which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, may reasonably be expected to be difficult or impossible”

[\(Risk Management Authority, 2025, p.93\).](#)

Legislation/policy/guidance

CARM does not have a legislative basis as such, although does feature within a range of policy drivers and practice guidance, including the [Framework for Risk Assessment Management and Evaluation \(FRAME\) with children aged 12-17: Standards, Guidance and Operational Requirements for risk practice](#) and [CYCJ practice guidance](#).

Information sharing with parents/carers

In line with GIRFEC, information should be shared with parents/carers unless doing so would be contrary to the best interests of the child and there are justifiable reasons for not doing so. Existing guidance states that provision of information to parents should not be an alternative to communicating decisions to the child, with best practice calling on both the child and parents directly receiving information on a face-to-face basis.

Consent to referrals / within processes

The child does not need to consent in order to be considered under CARM protocols, although their participation and engagement should be sought as a priority.

Multi-Agency Public Protection Arrangements (MAPPA)

FAQs

- *What about children who do not meet the threshold but have caused harm to others?*

For those children who do not meet the high threshold of risk of serious harm, alternative approaches can be taken including convening a ‘team around the child’ meeting, or care planning meetings. For those children who are accommodated, there may be merit in using Looked After and Accommodated Child procedures and review meetings to reflect on the risks posed by the child, alongside their wider needs.

- *What about children who have not appeared in court or at a Children’s Hearing yet?*

CARM processes can be used in this instance, with the finding of guilt not required in order to proceed with this approach. This may have a bearing on how the child and their family choose to engage and what they discuss. They should be advised to

seek legal advice. The outcome and progress of criminal proceedings should be reflected upon during scheduled CARM meetings, as this may have an influence on risk and on the child's circumstances.

- *How does CARM and child protection fit together?*

These two processes should be seen as complementary to one another, rather than separate and distinct. CARM and child protection processes both provide formal risk management processes. When a referral is made under CARM, an Inter-agency Referral Discussion (IRD) is convened. Likewise, where a child protection referral has been made and IRD completed, the decision could be to progress under CARM procedures. CARM processes are broadly similar to those of child protection and as with any formal risk management process, CARM must be overseen by each local Child Protection Committee (CPC). CARM must be subject to the same scrutiny and analysis as 'traditional' child protection measures and is reported on within national child protection statistics.

- *What is the interface between CARM and Prevent?*

Prevent – the UK government's strategy to counter the risk of terrorist related behaviours – may apply where there are reasonable grounds for concern that a child is at risk of becoming involved in terrorism or supporting terrorism [outlined within this guidance](#). Some children might be adopted into the Prevent Multi-Agency Panel process for managing terrorism related risks. Use of this approach does not preclude consideration of CARM (or indeed child protection and other approaches) if the threshold for those are met. Practitioners have often highlighted that the Prevent approach is not child centred nor rights respecting, and thus there may be a role for practitioners to ensure that the totality of a child's rights are taken into consideration. Further information about the use of Prevent in Scotland can be found from [Police Scotland](#) and the [Home Office](#).

Raising the age of referral to the Principal Reporter



Nature of risk/concern

Referral to the Principal Reporter is for the purposes of investigation into the child's circumstances to inform an assessment of whether the child is in need of protection, guidance, treatment or control, and whether it might be necessary for a compulsory supervision order (a "CSO") to be made in relation to the child by a children's hearing.

The Children (Care and Justice) (Scotland) Act 2024, once fully commenced, will extend the ability or duty (in the case of local authorities and Police Scotland), to refer to **all** children under 18 who meet the above criteria, filling a gap that currently exists in relation to some 16 and 17-year-olds ([Scottish Government, 2020](#)). This is anticipated to commence in 2027.

Referrals can be in relation to risk to a child under 18 or in relation to their behaviour that might pose risks to others.

The Principal Reporter in considering the necessity of compulsory measures will consider other options to support the child in compliance with [European Convention on Human Rights](#) Article 8, for example, if voluntary measures of supervision would meet the needs of the child. They will require information from local authorities, including on risk and need, to inform their decision making and assessment of whether there is a need for compulsory measures.

Age range

Referrals for children aged 16 and 17-years-old are mainly from local authorities and Police Scotland. Police Scotland can refer as a direct referral or jointly refer the child

to the Procurator Fiscal and the Principal Reporter as per the [Lord Advocate's guidelines on offences committed by children](#).

The Principal Reporter already makes investigations and assessments in relation to all children referred under 16; and also 16 and 17-year-olds who are already on compulsory measures, who have been referred before attaining the age of 16, remitted by the court having pled or been found guilty of an offence, or in some situations where the child has been placed in secure care by the Chief Social Work Officer. The Children (Care and Justice) (Scotland) Act will amend the definition of a child to cover anyone aged under 18.

The Principal Reporter has no direct role after a child reaches 18, but their decision on the referral will be made in the knowledge that any compulsory measure in place ends at the child attaining 18 years. Where a child's CSO is being terminated by a children's hearing, a children's hearing can make a statement placing a duty on a local authority to offer supervision or guidance to the child, which the Children (Care and Justice) (Scotland) Act extends to a maximum age of 19. The child may also have entitlements to continuing care or aftercare as a care leaver as detailed [above](#).

Criteria/threshold

Referrals can be made to the Reporter for 16 and 17-year-olds who are in need of protection, guidance, treatment or control, where there might be a necessity for compulsory measures.

The Principal Reporter can refer 16 and 17-year-olds to a Children's Hearing where the Reporter considers that there is sufficient evidence for a ground for referral under section 67 of the [Children's Hearings \(Scotland\) Act 2011](#)

and

it is considered that compulsory measures are necessary.

The grounds for referral have not been changed by the Children (Care and Justice) (Scotland) Act 2024 (although for children above the school leaving age, non-school attendance would not apply).

Legislation/policy/guidance

The referral criteria is as detailed in Part 6 of the [Children's Hearing \(Scotland\) Act 2011](#) and are:

- the child is in need of protection, guidance, treatment or control;
- and it might be necessary for a Compulsory Supervision Order to be made in relation to the child.

The Principal Reporter directs Reporters on the factors to be taken into account in their [decision making](#). The Children's Hearings Improvement Partnership has also

issued [guidance](#) for anyone thinking about making a referral to the Reporter. These will be updated in due course.

Information sharing with parents/carers

Any known parent of a child (and possibly other carers) will be notified of the referral unless that notification creates a risk of harm to another person. A parent or carer has no power to stop the referral being made. They can give their views to the Principal Reporter should they choose to do so.

Generally, parents have the right to be notified of any children's hearing, to receive all papers in relation to that hearing and attend the hearing. Some papers can be withheld where a statutory provision allows for this or all papers where certain exceptional circumstances apply.

Consent for referrals / within processes

A child does not need to consent to a referral being made but their views will be sought by the Principal Reporter before a decision is made on the referral.

FAQs

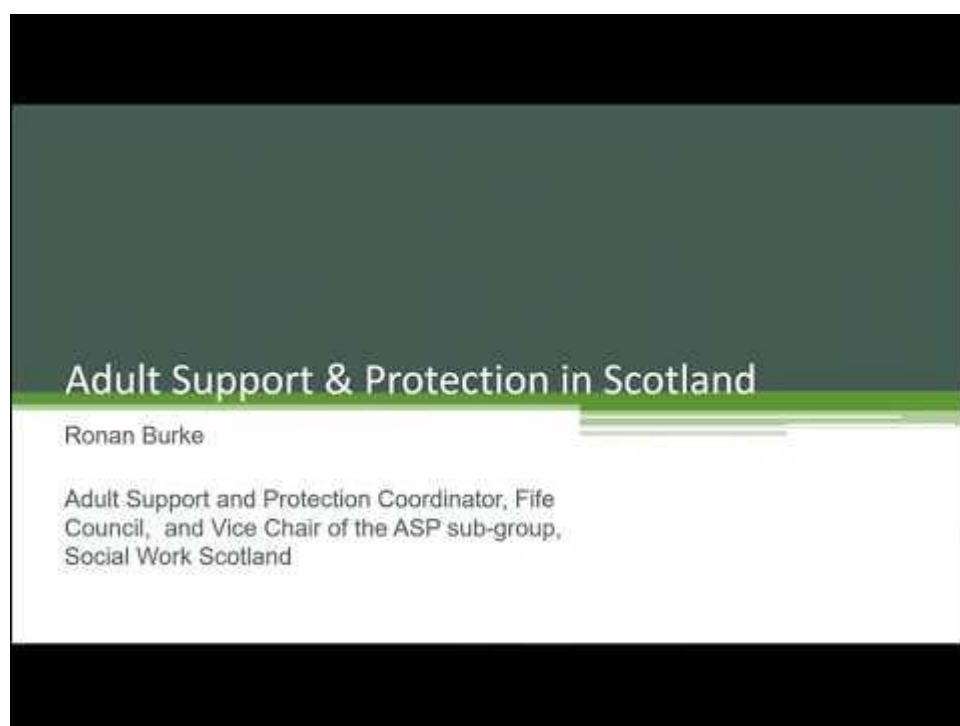
- *Can a child who is living independently be made subject to measures through the children's hearings system?*

Yes this is possible.

- *Is a CSO a barrier to accessing housing?*

There is no legal barrier to a child on a CSO accessing housing. There could be issues owing the housing providers policies or registration conditions. For example, Housing support services are defined under the [Public Services Reform \(Scotland\) Act 2010](#) which does not specify any reason why these services could not be available to a child, although a service could have a condition on age ranges. This could be removed or varied upon application to the Care Inspectorate.

Adult Support and Protection



Nature of concern/risk

In contrast to other approaches highlighted, Adult Support and Protection legislation defines all those aged 16 and above as an adult, and so can be used for those children to whom this resource relates. Section 3(2) of the [Adult Support and Protection \(Scotland\) Act](#) defines an adult as being at risk of harm if:

- another person's conduct is causing (or is likely to cause) the adult harm;
or
- the person is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm.

Adults (which for this whole section includes children aged 16 and 17) can be at risk of harm in various settings, be it in their own homes, in the wider community, or in a hospital setting. They also may be placed at risk through inappropriate arrangements for their care in a range of social or healthcare settings. Those causing harm can include families and friends, informal and formal carers, fellow users of residential and daycare services, and members of the public.

Section 53 states that "harm" includes all harmful conduct and gives the following examples:

- Conduct which causes physical harm;
- Conduct which causes psychological harm (for example by causing fear, alarm or distress);
- Unlawful conduct which appropriates or adversely affects property, rights or interests (for example theft, fraud, embezzlement or extortion);
- Conduct which causes self-harm.

The list is not exhaustive and no category of harm is excluded simply because it is not explicitly listed.

In general terms, behaviours that constitute harm to a person can be physical, sexual, psychological, financial, or a combination of these. The harm can be accidental or intentional, as a result of self-neglect, neglect by a carer or caused by self-harm and/or attempted suicide. Other forms of harm can include domestic abuse, gender-based violence, forced marriage, female genital mutilation (FGM), human trafficking, stalking, scam trading and hate crime. Some such cases will result in adults being identified as at risk of harm under the terms of the Act, but this will not always be the case.

The criteria for granting an assessment order (s12); removal order (s15); or banning order (s20) includes reference to the likelihood of the adult being “seriously harmed.”

Age range

ASP guidance and procedures are relevant from 16 years of age through the person’s entire lifespan.

Criteria/threshold

1. “Adults at risk” are people aged 16 and above who:

- Are unable to safeguard their own well-being, property, rights or other interests,
- Are at risk of harm, and
- Because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.

2. An adult is at risk of harm for the purposes of subsection (1) if:

- Another person's conduct is causing (or is likely to cause) the adult to be harmed, or
- The adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm

The Act places a duty on local authorities to make inquiries about a person's well-being, property or financial affairs if it knows or believes that the person is an adult at risk, and that it might need to intervene in order to protect the person's well-being, property or financial affairs.

Public bodies are required to work together with local authorities to take steps to decide whether someone is an adult at risk of harm, balancing the need to intervene with an adult's right to live as independently as possible.

The principles of the Act emphasise the importance of striking a balance between an individual's right to freedom of choice and the risk of harm to that individual. Any

intervention must be reasonable and proportionate. At times, there will be a need to carefully weigh up and consider the various principles, particularly where the adult at risk does not wish support or they themselves are the source of the risk.

The Act requires the principles to be applied when deciding which measure will be most suitable for meeting the needs of the individual. Any person or body taking a decision or action under the Act must be able to demonstrate that the principles in sections 1 and 2 have been applied. The principles in section 1 require that any intervention in an adult's affairs under the Act should:

- Provide benefit to the adult which could not reasonably be provided without intervening in the adult's affairs; and
- Be the option that is least restrictive to the adult's freedom.

A public body or office holder performing adult support and protection (ASP) functions must take into account the views of the adult and their family/carers; guardian or attorney of the adult; and any other person who has an interest in the adult's well-being or property, which are known to the public body or office-holder. The adult must also be provided with the information needed to keep them involved in any decision, recognising their background and treating them equally as they would treat others.

The Act provides a framework for intervention and support for adults at risk of harm. It provides measures to identify and to provide support and protection for those individuals who are vulnerable to being harmed whether as a result of their own or someone else's conduct.

An ASP referral can be submitted to the council where the person is by any individual, including by the individual themselves. In some areas where health and social care is integrated, referrals may be made directly to social work departments.

An individual's vulnerabilities, health conditions and abilities can fluctuate and evolve over time. Practitioners should be alert to the need for re-assessment or for re-evaluation of an individual's circumstances against the three-point criteria, as this may have changed

Legislation/policy/guidance

- [The Adult Support and Protection \(Scotland\) Act 2007](#)
- [Adult Support and Protection \(Scotland\) Act 2007: Code of Practice](#).
- [ASpire hub](#) is a website for everyone working in ASP in Scotland to access and share resources.

Information sharing with parents/carers

Regardless of age, the individual will be asked if relevant information can be shared with parents, carers and relevant others. For all 16 and 17-year-olds who are referred for ASP or Child Protection, consideration should be given to sharing

information with parents, carers, and/or other professionals to inform risk assessment and protection. Decisions on sharing information with or without permission for this age group are informed by the individual circumstances of the case. In certain circumstances information must be shared as a key part of keeping a child safe from harm. Where there is a child or adult protection concern, relevant information should be shared with the relevant professionals without delay (including social work, health and police), provided it is justifiable, proportionate and lawful to do so, and based on the potential or actual harm to adults or children at risk. The rationale for decision-making should always be recorded. People should not be pressured to consent to their information being shared. However, there may be times where information is shared lawfully without gaining the consent of the people to whom the information pertains. Further information around UK GDPR and consent in respect of data sharing can be found on the [Information Commissioner's Office](#) website.

Further information regarding the sharing of information under Adult Support and Protection processes can be found in the [ASP Code of Practice](#), including a checklist for practitioners, to guide decisions about whether or not to share information. If possible, the individual's consent should be attained prior to sharing information (e.g., sharing records) but, for the avoidance of doubt, where disclosing information to the appropriate authorities seeks to address a perceived risk of harm to that individual, it is in the public interest to do so. This legal duty applies to all employees and officers of relevant public bodies and overrides any general duty of confidentiality. Where the adult is incapable of consent, it would be good practice to approach the [Office of the Public Guardian](#) to ascertain whether a guardian or attorney may consent on their behalf.

Where no guardian or attorney has such powers, consideration may be given to whether it is appropriate to use the provisions in the [Adults with Incapacity \(Scotland\) Act 2000](#) or Section 34 of the [Mental Health \(Care and Treatment\) \(Scotland\) Act 2003](#). See [Mental health legislation](#) for more detail.

Consent to referrals / within processes

Consent is not required for an Adult Support and Protection referral to be submitted. It is important to be open and transparent with the person who has been referred via ASP, and vital that all decisions and rationale are recorded

The adult's views and wishes are central to ASP, and every effort should be made at each stage of the process to ensure that barriers to giving their views are minimised. Undue pressure on the person from another party is one barrier which can occur.

See also the information above re: information sharing

FAQs

- *Does an individual have to be assessed as lacking capacity before ASP procedures can be utilised?*

The criteria makes no reference to capacity. The criteria is the 'inability to safeguard' which is the whole of an individual's circumstances taken into account in relation to the context of the harm and the person doing the harm. The ability or inability to safeguard should be viewed through a trauma informed lens. A capacity assessment may be helpful, as part of the ASP process, for some adults **(where capacity concerns have been raised)**, in relation to an ASP risk assessment, concerning specific issues. Adults with capacity and those without capacity, can both be supported and protected via the ASP Act.

- *What is the relationship between ASP and child protection?*

The [National Guidance for Child Protection in Scotland \(2021\) \(updated 2023\)](#) points out the duties of practitioners to consider this issue, in particular paragraph 2.200 which states that

“To ensure that individuals do not fall between eligibility and service criteria, coordination and collaboration is necessary between child and adult services at both operational and strategic levels. Arrangements for linking up child and adult services in relation to support and protection must be agreed through Chief Officer’s Groups and Child and Adult Protection Committees as described above”.

In light of this, collaboration between all relevant partners is essential to ensure that unmet risk and need does not go addressed. Participation of such agencies within IRD process is one way to achieve this.

Mental health legislation



Mental Health & Children

Legislative Supports



Nature of risk /concern

The [Mental Health \(Care and Treatment\) \(Scotland\) Act 2003](#), the [Criminal Procedure \(Scotland\) Act 1995](#), and the [Adults with Incapacity \(Scotland\) Act 2000](#), ensure that individuals who lack capacity to consent to medical treatment receive appropriate care while safeguarding their rights and safety.

Under the Mental Health Act, several statutory civil interventions may be considered when there is concern about the risk to a person's health, safety, or welfare, or in circumstances where the safety of others is at risk. These interventions are designed to ensure that individuals with a mental disorder - defined as any mental illness, personality disorder, or learning disability - receive the necessary assessment and treatment. The Mental Health Act is guided by general principles, including the least restrictive option and the maximum benefit to the patient, which inform decision making and ensure that compulsory measures are used only when absolutely necessary to mitigate significant risk. In instances where the person posing or encountering the risk is a child, additional consideration must be given to their welfare, including the provision of appropriate care in child specific settings.

Provisions for “mentally disordered offenders” in Scotland are primarily set out in Part VI of the Criminal Procedure Act. These provisions allow courts to assess, treat, and manage individuals with mental disorders who are involved in criminal proceedings.

Guardianship of people aged 16 or 17 under the Adults with Incapacity Act allows a court appointed private individual or local authority representative, known as a guardian, to make decisions on behalf of someone who lacks capacity due to mental

disorder or inability to communicate. For private applicants, specified powers may include the authority to consent to medical treatment.

Age range

Under the Mental Health (Care and Treatment) (Scotland) Act 2003, a child is defined as a person under the age of 18 years.

The Adults with Incapacity (Scotland) Act 2000, can be applied to adults over the age of 16 years.

These variations may prove challenging when responding to the needs of 16 and 17-year-olds.

As of the Age of Criminal Responsibility (Scotland) Act 2019, children under 12 years cannot be held criminally responsible for their behaviour therefore provisions under the Criminal Procedure (Scotland) Act 1995 would only apply to children aged 12 and over.

In the three months prior to a child's 18th birthday, alternative adult service provision should be arranged as part of the transition from Child and Adolescent Mental Health Services (CAMHS) to Community Mental Health Teams (CMHT) or an appropriate inpatient resource. All children, those under 21, and care experienced people up to the age of 26 should have their care informed by the [Supporting Children and Young People Experiencing a Mental Health Crisis Framework](#).

Criteria/threshold

The main certificates and orders used to ensure that care and treatment are provided, as well as to manage risk, are:

- Emergency Detention Certificate (EDC) - Civil

Allows a person to be detained in hospital for up to 72 hours for assessment and determining - though not authorising - treatment. It can be granted by a single medical practitioner (G.P.) in urgent circumstances if there is a significant risk to the person or others without detention, and if a mental disorder and significantly impaired decision-making ability are likely. Consultation with a Mental Health Officer (MHO) is advised where practical.

- Short-Term Detention Certificate (STDC) - Civil

Allows a person to be detained in hospital for up to 28 days for available treatment or assessment under the Act. It requires authorisation from both an Approved Medical Practitioner (AMP) and an MHO. The criteria include: the person is likely to have a mental disorder; their ability to make decisions about medical treatment is significantly impaired; there is a significant risk to the person's health, safety, or welfare, or to the safety of others if they are not detained; and the order is necessary taking into account the principles of the Mental Health Act.

- Compulsory Treatment Order (CTO) - Civil

Is a longer-term measure, initially lasting up to six months, that authorises detention in hospital or which grants compulsory community based measures. It can be sought by an MHO via a Mental Health Tribunal (MHT) through a written report accompanied by two medical reports, one of which must be completed by a child specialist AMP. The criteria for a CTO include: the presence of a mental disorder; the availability of medical treatment that can prevent the disorder from worsening or alleviate its symptoms; a significant risk to the individual or others if treatment is not provided; significantly impaired decision-making ability regarding treatment; and that the order is necessary, all of which must be met.

- Section 47 Adults with Incapacity Act - Civil

Where criteria under the Mental Health Act is not met and treatment for self-harm is being sought, Section 47 of the Adults with Incapacity Act may authorise medical treatment for individuals aged 16 years and over who lack capacity to consent, provided a Section 47 certificate is completed by a Doctor or authorised healthcare professional. A Section 47 medical certificate does not permit the transportation of an individual to hospital where consent is not authorised.

- Mentally Disordered Offenders - Criminal

With regard to mentally disordered offenders, the Criminal Procedure Act allows courts to divert individuals from standard sentencing toward appropriate mental health care. These include Assessment Orders for short-term hospital evaluation, Treatment Orders for care while awaiting trial or sentencing, and Compulsion Orders for longer-term hospital treatment. In serious cases, a Restriction Order may be added to limit discharge without ministerial approval. Hospital Directions enable transfer from secure care provision to hospital for treatment. Once assessment or treatment is concluded, the patient may return to secure care (or custody if aged over 18). These measures ensure that offenders with mental disorders receive care in line with legal safeguards and public safety considerations. Exclusions to mental health disposals under the Criminal Procedure Act apply when legal or clinical criteria are not met. These include cases where the individual does not have a recognised mental disorder, poses no significant risk to themselves or others, or where no suitable treatment is available. Disposals may also be excluded if required medical reports are incomplete, or if the Mental Health Tribunal does not approve the application.

Section 328 of the Mental Health Act, states that a person is not to be considered mentally disordered solely by reason of any of the following: sexual orientation; sexual deviancy; transsexualism; transvestism; dependence on, or use of, alcohol or drugs; behaviour that causes, or is likely to cause, harassment, alarm, or distress to others; or acting in a manner that no prudent person would act.

Guardians do not have the legal authority to consent to a psychiatric inpatient admission for an adult who lacks capacity.

Legislation/Policy/guidance

- [Mental Health \(Care and Treatment\) \(Scotland\) Act 2003](#)
- [Scottish Government – Mental Health Legislation and Guidance](#)
- [Mental Welfare Commission – Mental Health Act](#)
- [Recent Mental Health Legislation PDF – Mental Health Tribunal for Scotland](#)
- [Age of Legal Capacity \(Scotland\) Act 1991 – legislation.gov.uk](#)
- [Criminal Procedure \(Scotland\) Act 1995](#)
- [Age of Criminal Responsibility \(Scotland\) Act 2019](#)
- [Adults with Incapacity \(Scotland\) Act 2000 – legislation.gov.uk](#) [Scottish Government Code of Practice Volume 1](#) General Framework and Civil Measures
- [Volume 2 – Code of Practice \(PDF\)](#) Criminal Justice Provision and Procedures
- [Volume 3 – Code of Practice \(PDF\)](#) Tribunal Procedures and Rules
- [Criminal Procedure Rules](#) including those involving Mental Disorder and Children

Information sharing with parents/carers

Carers have the right to be consulted, informed, and supported when someone they care for is receiving treatment under the Mental Health Act. Their views must be considered in decisions about care and compulsory measures. Carers are entitled to receive relevant information to help them support the person they care for however, this must be balanced with the patient's right to confidentiality. Under Section 250 of the Mental Health Act, an individual over the age of 16 may nominate a Named Person. For children aged under 16, a parent is identified as the 'default' Named Person (this role is different from the 'named person' role in relation to services for children set out in GIRFEC that continues to operate on a non-statutory basis). The Named Person plays a key role in supporting and safeguarding the rights of someone receiving mental health care. They have the right to be consulted and informed about significant decisions, such as applications for detention or compulsory treatment, and can access relevant information unless the patient objects. The Named Person may attend Mental Health Tribunal hearings, receive copies of reports submitted to the Tribunal, make representations, and appeal certain decisions. They may also be eligible for legal aid to support their involvement. For a child under the age of 16 years, it is the responsibility of the MHO to identify the Named Person, who is usually someone with parental rights and responsibilities.

Consent to referrals / within processes

The Mental Health Act allows for treatment without consent if specific legal criteria are met, for example, through the application of a STDC or a CTO. However, the use of force to administer treatment under a community-based CTO cannot be carried out in community settings, such as an individual's home. Even when treatment is given without consent, the Mental Health Act emphasises respect for the patient's views, and patients have the right to advocacy, advance statements, and appeal

mechanisms. Additional safeguards are in place for procedures deemed invasive under the Act, such as electroconvulsive therapy, nasogastric feeding or long-term medication. Under the Age of Legal Capacity (Scotland) Act 1991, individuals aged 16 years and above are presumed to have full legal capacity to consent to medical treatment. A child under 16 years old can be deemed to have capacity if they are assessed as having sufficient understanding of the nature and consequences of the treatment.

FAQs

- *Why is use of the Mental Health Act helpful?*

Using the Mental Health Act for children ensures that those experiencing mental disorder receive timely, structured, and rights-based care, even when they cannot consent. The Mental Health Act provides legal safeguards, promotes early evidenced based intervention, and requires that the child's welfare be a primary consideration. It enables access to advocacy, appropriate treatment settings, and involvement of carers, while supporting a smooth transition to adult services at age 18.

- *What happens if a 16 or 17-year-old is admitted to an adult mental health ward?*

From 16 years of age, children may start to interact with supports and services for adults. There is no universal transition point for children and young people's services. Some cease at 16 years, and others continue to age 18. This is particularly important in relation to crisis or unscheduled care. If there is an urgent mental health issue, a 16–18-year-old could, in very rare circumstances, be admitted to an adult mental health ward if no beds are available in an adolescent unit. The '[Admission to adult mental health wards for under 18's Best Practice Guidance](#)' (2020) is clear that children of this age should be admitted to a specialist CAMHS ward but provides guidance on how best to manage admissions when this is not possible.

- *How can young people be supported in transitioning to adult mental health services?*

Providing support to help a child or young person feel in control ahead of transition points has the potential to reduce the feelings of helplessness. Putting in place specific support, such as [Transition Care Plans](#) in the case of moving between CAMHS and adult mental health services, can help improve understanding and increase feelings of control around transition points and handovers.

Multi-Agency Public Protection Arrangements (MAPPA)



Nature of risk/concern

The core purpose of MAPPA is public protection and managing the risk of serious harm parts of an individual's behaviour may present by providing a statutory framework for "responsible authorities" to jointly establish arrangements for assessing and managing such risk. The definition of serious harm is the same as for CARM as detailed above. See the section on [FRAME for 12-17-year-olds \(CARM\)](#) for more information.

Age range

Any child aged 12 or over the age of criminal responsibility, can be made subject to MAPPA. In practice, it is very rare for children of any age to be made subject to MAPPA, but when this occurs it is almost exclusively those aged 16 or 17-years-old. The requirements of MAPPA can prove particularly challenging for children to adhere to - for example if contact with other children, particular places or online activity is restricted or prevented-and be experienced as highly punitive. As a child's accommodation would need to be assessed and approved, accessing this can be challenging. Whilst this may be necessary to manage the level and types of risk presented, a developmental approach to understanding risk and the impact of restrictions is particular important in planning and supporting children within MAPPA. When MAPPA involves a child it must be remembered that all public bodies require to adhere to the UNCRC Act and respect the rights of children enshrined within this legislation.

The length of time an individual is subject to MAPPA will depend on the length of SONRs in the case of registered sex offenders or legal order for restricted patients, or when a change in circumstances means the criteria for the risk of serious harm is no longer met for individuals in this category. Therefore, children could continue to be subject to MAPPA beyond their 18th birthday.

Criteria/threshold

MAPPA arrangements apply to the following cases:

- **Registered sex offenders:** individuals who have been convicted of an offence under Schedule 3 [Sexual Offences Act 2003](#) that requires they comply with Sex Offender Notification Requirements (SONRs) under Part 2 of that Act;
- **Restricted Patients:** individuals who are subject to a compulsion order with restriction order, a hospital direction or a transfer for treatment direction meaning they are subject to criminal justice measures and special restrictions under the [Mental Health \(Care and Treatment\) \(Scotland\) Act 2003](#);
- **Other Risk of Serious Harm:** individuals who do not fit into the above categories; but who by reason of their conviction are considered by the responsible authorities to pose a risk of serious harm to the public. This could include individuals where the conviction is for terrorism offences.

Children who meet the above criteria must be subject to one of three risk management levels: Routine risk management; Multi-Agency risk management; or Multi-Agency Public Protection Panels (MAPPP). This [information sheet](#) on Managing the risk of serious harm presented by young people provides more information on the particular approaches and considerations that should be applied when children are subject to MAPPA.

Legislation/policy/guidance

The underpinning legislative basis for MAPPA is sections 10 and 11 of the [Management of Offenders etc. \(Scotland\) Act 2005](#). [The Management of Offenders etc. \(Scotland\) Act 2005 \(Specification of Persons\) Order 2007](#) specifies the persons or bodies with duty to cooperate.

[Scottish Government \(2022\) Multi-Agency Public Protection Arrangements \(MAPPA\): National Guidance](#) sets out the responsibilities of agencies charged with implementing MAPPA. The implementation of MAPPA for children will also be enhanced through the inclusion of the principles for managing the risk of serious harm with children as detailed in [Youth justice: risk assessment management framework and evaluation guidance](#). See the section on [FRAME for 12-17-year-olds \(CARM\)](#) for more information.

Information sharing with parents /carers

Parents /Carers are not automatically informed of their child being made subject to MAPPA or invited to attend meetings/case conferences but they should be unless it is not in the child's best interests. In this scenario, parents/carers should be provided with information about MAPPA and included in correspondence. They should be included in assessing the child's strengths, needs and risks, development of the child's plan and part of systemic interventions and risk management strategies including contingency planning, as well as being and supported to attend meetings/case conferences.

Consent to referrals / within processes

Consent is not required for an individual to be made subject to MAPPA.

FAQs

- *How do MAPPA and CARM relate?*

CARM can apply where parts of a child's behaviour meets the definition of serious harm detailed above, whereas MAPPA will only apply where the child has been convicted of a sexual offence and is a registered sex offender, a restricted patient, or has been deemed to present other risk of serious harm. In these situations, MAPPA processes must apply. A child could be supported through CARM processes prior to a conviction that would result in a child being made subject to MAPPA or could be subject to both CARM and MAPPA simultaneously which would have similar considerations. However, approaches within CARM and MAPPA can differ; for example CARM would focus more widely on the child's welfare and development, and a CARM plan would be a child's plan which generally would be more holistic than a MAPPA risk management plan. The CARM chair and MAPPA Co-ordinator should work closely to agree on the most appropriate local arrangements to manage the risk of serious harm presented by aspects of the child's behaviour, including where a child is due to turn 18 and serious concerns remain but the child is not subject to MAPPA (Scottish Government, 2021).

- *What should happen when a child transitions from CARM to MAPPA?*

Local arrangements and case-by-case discussions should take place between the MAPPA coordinator and CARM chair where a child is transitioning from CARM to MAPPA. Attendance of the MAPPA chair at the last CARM meeting and vice versa is encouraged. The child should continue to have a Child's Plan and within MAPPA meetings and where possible, there should be representatives from childcare/youth justice agencies present to ensure that processes adopted are suited to the child ([CYCJ, 2017; Scottish Government, 2021](#)). It is also critical to ensure the child and their family understand any differences of expectations and implications of non-

compliance with any additional requirements such as SONR, between MAPPA and CARM and are supported throughout this process in a developmentally, trauma-informed manner (Scottish Government, 2021).

Acknowledgements

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Appendix 1 Case scenarios with potential actions

At two events attended by practitioners and policy leaders the following case studies were employed to prompt reflection on, and discussion of, professional decision-making when responding to risk with 16/17 year olds. Participants were invited to consider what each of the aforementioned approaches could offer the children involved and which factors would inform decision making. This information is reflected in the potential actions sections along with information developed by each of the presenters and contributors to this resource.

The scenarios (or versions of these scenarios) were previously considered by the [cross-system working group](#) in 2018 when proposing changes to the Children's Hearing System. They have been adapted where necessary to take cognisance of the changes through the Children (Care and Justice) (Scotland) Act 2024 and should be read as if we are already operating post-implementation of the change to Children's Hearing System that raises the age at which children can be referred to SCRA.

They present simplified summaries of complex circumstances and therefore cannot fully reflect the lived experience of individual children or the dynamic nature of risk, need and protective factors however do instigate debate and reflection.

Practitioners are encouraged to consider these scenarios through a rights-based, trauma-informed and strengths-oriented lens, recognising that children's situations are influenced by wider contextual, relational and systemic factors. Real-life assessment, analysis, and planning should also focus on understanding unmet needs, rights, strengths and protective factors, and how these interact over time. The examples should therefore be read as starting points for exploring professional reasoning rather than as complete representations of a child's circumstances, nor of their views and experiences or the full range of possible responses.

Jane: exposed to sexual abuse

Jane has just turned 16 and lives with her parents and two sisters aged 14 and 12. She has a learning disability and rarely leaves her home. She confides in her sisters that she has been sexually abused by her father for the past three years. One sister shares this with a teacher at school who in turn contacts police and social work.

Potential actions:

Based upon the available information, instigation of child protection procedures is the most likely first consideration for Jane and her siblings. This is owing to the nature of the abuse and risk of significant harm. All three children will be considered in relation to child protection processes. Consent for the referral would not be required but the teacher should have informed Jane and her siblings that this referral is being made.

Following an Inter-Agency Referral Discussion (IRD) it is likely that a Child Protection investigation would be undertaken, with an interim safety plan established whilst the investigation is undertaken. Given Jane's learning disability, having a representative from adult social work or disability services involved in the IRD may be advantageous. This will allow holistic information about Jane and her family's strengths, needs, circumstances and risks to be shared, as well as about approaches taken so far (for example the police investigation), and a multi-agency decision reached on how to proceed. If these agencies are not present at the IRD then their insights and advice should be made available to those attending the IRD. Relationships between family members, alongside Jane's mother's needs and experiences (for example, of domestic or sexual abuse) and views would also warrant further assessment.

It is likely that the IRD will make a decision to undertake joint investigative interviews (JIIs) with Jane and her sisters which would be undertaken jointly by Police and social work. In most areas this would likely be undertaken using the Scottish Child Interview Model (SCIM) to capture any evidence and support social work assessment of risk. In some areas, this interview and support to the children would be undertaken in a Bairns Hoose. A range of agencies will be involved in planning the interview including the development of a Plan for the Child's Needs -this would include a speech and language therapist if there were concerns about Jane's communication needs.

This could likely lead to a Child Protection Planning Meeting and registration for all three if a view was taken that Jane and her sisters continued to be at significant risk of harm. Precise details and outcomes of this meeting would depend on a number of matters including whether the father remained in the family home or was having unsupervised contact with his children; the level of acceptance from the mother regarding her husband's alleged behaviour and any risks that she was experiencing in her own right; and the family's attitudes and behaviours towards Jane, which could be significant factors in risk management. These considerations and the safety of the children would also inform what information was shared with Jane's parents. Social work would work to support the family to remain at home together if possible.

An emergency Child Protection Order could be sought for Jane or her sisters if the assessment of risk meets the criteria for this i.e. was significant and immediate. In terms of standard practice in these circumstances, alternative measures would need to be explored with the family to preclude the need for both the necessity and immediacy of a Child Protection Order which as a significant legal intervention in a child's life would always be regarded as a last resort.

Referral to the Scottish Children's Reporter Administration (SCRA) would also be considered during any child protection procedures. Jane and her younger sisters could be referred to a Children's Hearing given their close connection with a person who may have committed a Schedule 1 offence. The standard of proof within the children's hearings system is the balance of probability and therefore grounds could be established even if the father has not been convicted. The Hearing could then consider whether the three girls should be made subject to compulsory measures of care to become looked after at home or away from home or other measures put in place to protect them. Conditions could also be placed on the children's contact with their father. Compulsory measures would provide a statutory basis for intervention and support with the family. In addition, if Jane became a looked after child (either at home or elsewhere) and these measures terminated after her 16th birthday, Jane would be a care leaver and could have entitlements to aftercare up until the age of 26.

Adult Support and Protection (ASP) processes could be progressed following an ASP referral and discussion. ASP processes could lead to practitioners making inquiries about Jane if they know or believe that she is an adult at risk and that they might need to intervene in order to protect her. Multi-agency information sharing as part of the inquiry process – including any use of investigative powers – underpinned by the ASP Act. Regardless of criminal proceedings and outcome, a Protection Order (including a Banning Order) via ASP processes may be possible.

Adults with Incapacity (Scotland) Act 2000 (AWI Act) powers may also be relevant as Jane is over the age of 16 and it could be argued that she is unable to make decisions due to mental disorder or communication difficulties dependent on the impact of her learning disability.

Possible actions include undertaking an assessment of her capacity, and if she is deemed to lack capacity, decisions may be made on her behalf under AWI provisions. Guardianship or Intervention Orders could be sought that leads to a guardian (e.g., a trusted adult or local authority) being appointed to make welfare decisions, including where she lives and who she has contact with. Should her physical or mental health deteriorate decisions about Jane's medical or psychological treatment can be made by a proxy if she cannot consent herself. If Jane was already subject to a Guardianship Order with her parents - under Section 10 of the AWI - the Local Authority has a duty to supervise Welfare Guardians. Where Guardians do not appear to be acting in the person's best interest, are failing to act, or where there is suspected harm, consideration may be given to application of ASP. Additional visits are likely to take place. Social Workers may refer to the Mental Welfare Commission who have powers to investigate and may make formal

recommendations, however where concerns are significant, legal remedies may be sought via the Sheriff Court. At the point of review, the court has a number of options that may be considered including; variation of the order, suspension of the Guardian, or removal of the Guardian. Alternative orders may be considered under AWI.

The Mental Health (Care and Treatment) (Scotland) Act 2003 is an alternative legislative instrument to utilise, with this Act enabling a Mental Health Officer (MHO) to assess Jane's mental health needs and coordinate services, especially if trauma or anxiety is affecting her well-being. This could lead to a range of trauma-related or community mental health support. If Jane is considered vulnerable due to her mental health, protective measures (e.g., supervised accommodation or restricted contact with her father) can be implemented.

ASP, AWI and mental health legislation could all be used to support Jane post-18 should her needs require this and the criteria for these approaches be met.

Whichever approach is adopted, support to Jane and her family throughout will be key. Consideration should also be given to securing advocacy for Jane in order to support her to participate in, and influence, the discussions and decisions relating to her life.

Simone: risk of exploitation

Simone is 16 and was subject to a Compulsory Supervision Order for seven years, due to concerns over parental neglect. She had been in a children's house for 18 months when her Compulsory Supervision Order was terminated at her request. She subsequently left the children's house after an argument with a staff member and moved back in with her mother. Her mother's use of alcohol is problematic and she has now contacted the social work department because:

- Simone is frequently out late at night and has been brought home under the influence of alcohol by the police.
- Simone has physically assaulted her mother.
- Simone is often in possession of money that she cannot account for and has been seen in the company of older men, most commonly an adult male in his 40s who neighbours believe has connections to online sex workers.
- Her mother claims that Simone is scared of some of the people she is in contact with.

Simone states that she does not want any help from social workers; she wants to be left alone now that she is 16. She has refused to meet with anyone since the first home visit undertaken by practitioners.

Potential actions

Simone appears to be at risk of significant harm and therefore child protection proceedings could be an appropriate option. An IRD to discuss concerns and assess immediate risks could be convened and support the focus being on the risks being experienced by Simone rather than solely focusing on her behaviour. Consideration should be given to involving ASP colleagues as part of the IRD and given the nature of the concerns police could have useful information about the older men Simone has been seen with. It is likely that this will lead to further assessment of potential Child Sexual Exploitation / Criminal Exploitation potentially using specialist tools to consider risk, including whether trafficking has taken place. This may lead to a child protection planning meeting, with practitioners adopting a contextual safeguarding approach to map where she is spending her time and where she feels safe/unsafe. This may include considering if any other children/young people may be at risk in this context.

As part of this investigation consideration could be given as to the circumstances of Simone leaving the children's house and as to whether a return might be a suitable option for Simone. Simone could voluntarily be accommodated, if agreeable, dependent on local available options. Efforts to repair relationships between Simone and her mother could be beneficial, as would consideration of the support Simone's mother requires both in her own right and to provide Simone with the guidance, care and support she requires. Simone could be entitled to ongoing support in terms of aftercare from the local authority, supported by the current legislation in Scotland. Practitioners involved may be able to engage with her on this basis and offer advice and support with finances, housing and transition to independent living.

If Simone was to be charged with an offence which may be as a result of her being subject to exploitation, then those supporting her should consider whether the [Human Trafficking and Exploitation \(Scotland\) Act 2015](#) is relevant, with regards to the non-prosecution of victims of exploitation. It will be important that the multi-agency team around Simone recognise and understand that she is a victim. Given potential concerns over trafficking and criminal exploitation, one possible action could be referral to the Home Office's National Referral Mechanism (NRM). The NRM is a framework for identifying and supporting adult and child victims of trafficking. Alongside child protection processes, a referral to the NRM could be considered to look into the safety of Simone. Children (defined as those under 18 in this instance) do not need to consent to a NRM referral, adults must provide consent. Referrals are often made by Police, particularly when they are the first agency to encounter the child during the course of their exploitation. However, decisions regarding NRM referrals can also be made during the IRD meetings. Although NRM referrals are not mandatory, they are considered good practice. They can also be beneficial in cases where charges are brought against the child. The NRM [Toolkit for First Responders](#) created by [Migration Scotland](#) may be beneficial to practitioners.

Whichever approach is adopted, work will need to be undertaken to engage Simone and build relationships with Simone and her mother. Previous relationships with social workers and staff within the children's house could be considered and explored for scope to rebuild or possible routes of engagement. Understanding Simone's views and understanding of her current experiences will be crucial.

Simone could be referred to SCRA due to being exposed to someone whose conduct is likely to cause her harm, or in relation to her own behaviour and its impact on herself or others.

After taking into consideration Simone's views and her best interests, the Hearing could consider whether a Compulsory Supervision Order - either at or away from home (including potentially within the previous children's house) - would be both necessary and advantageous, whilst a measure could be included to restrict her from seeing specific individuals, thus affording her greater levels of protection.

Consideration could be given to the use of a Movement Restriction Condition (MRC) as a means of supporting her to stay within her home, with the criteria for use of this changing through an amendment to Section 83(4) the 2011 Act via the Children (Care and Justice (Scotland) Act. When commenced, the new criteria will be:

- (a) that the child's health, safety or development is at risk **or**
- (b) that the child is likely to cause physical or psychological harm to another person.

Given that Simone has previously physically assaulted her mother and her mother's problematic alcohol use and history of neglect of Simone, the risks of requiring Simone to remain within the home subject to an electronic tag for specified periods of time should be specifically considered as part of the assessment of suitability of this measure.

From information currently known the above approaches appear to be the most suitable but this could change as further assessment is undertaken. Simone does not appear to meet the ASP 3-point criteria but this should be kept under review, with relevant prompts for Children's Services to consider. Depending on assessment of Simone against the ASP 3-point criteria, a Banning Order could also be relevant in these circumstances.

ASP may be appropriate for consideration for Simone's mother, given her apparent vulnerability to Simone (and perhaps others); and problematic alcohol use. More information to consider against ASP 3-point criteria would be of benefit so that relevant referral(s) could be made in regards to the mother.

If there is dubiety over Simone's capacity, assessments could be undertaken under the Adults with Incapacity (Scotland) Act 2000. This could relate to impaired decision-making related to trauma, substance misuse, or mental disorder. If she is found to lack capacity, a guardian (e.g. local authority or trusted adult) could be appointed to make decisions about her welfare, finances, or accommodation. If Simone refuses treatment but lacks capacity, a Section 47 certificate may allow treatment to proceed in her best interests. However, capacity must be assessed specifically for each decision, and refusal of help alone does not imply incapacity. Under the Mental Health (Care and Treatment) (Scotland) Act 2003 a number of possible actions could be taken, with a MHO assessing Simone's mental health needs and coordinating services, especially if her behaviour suggests risk to self or others.

If Simone is deemed to have a mental disorder and poses a significant risk, she may be subject to emergency or short-term detention for assessment and treatment. A Compulsory Treatment Order (CTO) could be considered if ongoing treatment is necessary and she continues to refuse help.

These measures require medical and legal oversight and must respect her rights under the Act.

Lee: displayed Harmful Sexual Behaviour

Lee is 17 and was subject to a Compulsory Supervision Order for many years due to him being missing from home, parental neglect, domestic violence and concerns within school over behaviour and attendance. The order was terminated when Lee was 15 because he had made genuine progress, securing a placement on a training programme and residing with foster carers who were prepared to continue to care for him regardless of whether there was a Compulsory Supervision Order in place or not. Several months after the termination of the Compulsory Supervision Order, Lee – who is now 17, but was 16 at the time of the offences - was charged with two counts of rape of two different girls, both aged 15. He was also charged with physical assault of one of the girls. Lee found the time prior to trial extremely difficult; he had been identified on social media and subsequently received a number of significant threats from members of the local community. He pled guilty at the earliest opportunity, although continues to minimise what happened. He subsequently received a three-year Community Payback Order and was placed on the Sex Offenders Register for three years.

Potential actions

At the point of conviction, the court could have sought advice from a Children's Hearing and could then remit the case to a Children's Hearing for disposal. The rules on remittal will change when the Children (Care and Justice) (Scotland) Act is fully commenced, allowing almost all children to be considered for remittal and make remitting for advice a requirement in some cases. It will also allow in certain cases, including where a child is subject to Sex Offender Notification Requirements, for the court to make such a measure whilst also remitting the child's case to the children's hearings system for disposal. This did not happen in this instance.

Even though he is now subject to a Community Payback Order, there may be scope to refer Lee to the Children's Hearing System for consideration of whether a further period of compulsory supervision would be of benefit. This would not be in relation to the sexual offences, and would require to focus on any wider concerns that are identified.

Given Lee remained in his foster care placement under a voluntary arrangement, Lee would remain a looked after child and therefore would have statutory aftercare entitlements. Additional support to Lee could be provided through this route. Owing to the nature of Lee's conviction, Lee will be placed on the Sex Offenders Register, requiring that he comply with Sex Offender Notification Requirements and must become subject to Multi Agency Public Protection Arrangements (MAPPA). Via these requirements and the MAPPA processes, the risk of harm, reoffending and other relevant aspects of his life can be monitored and addressed.

Care and Risk Management (CARM) procedures (under local Child Protection procedures) may also be an option until Lee turns 18, should he meet the criteria. Following an IRD, CARM could be utilised as soon as information has come to light that suggests Lee poses this heightened risk of harm to others, and therefore CARM could provide a forum through which he can be supported and supervised before the

trial takes place, and therefore before any finding of guilt. Following conviction CARM could continue to be in place, although MAPPA would also be required given his Sex Offender Registration. If both CARM and MAPPA processes were used simultaneously Lee would require support to understand the differences between these processes. CARM would consider many of the same issues covered through MAPPA, but would also seek to consider wider issues relating to his welfare and development. Another advantage in using CARM would be the ability for Lee and his carers to be fully involved in the planning process. The CARM chair and MAPPA Co-ordinator should work closely to agree on the most appropriate local arrangements to manage the risk of serious harm presented by aspects of Lee's behaviour. Upon conviction Lee would be made subject to MAPPA procedures, however the decision as to whether he should also remain within CARM procedures would remain the decision of those agencies supporting Lee, and a focus should be on providing a smooth transition between processes. Specific consideration of Lee, his needs, and local arrangements should inform this transition.

To assist in a smooth transition, attendance of the MAPPA chair at the last CARM meeting, and of youth justice/childcare staff at future MAPPA meetings should be encouraged. Lee should continue to have a Child's Plan and efforts should be made to respond to Lee as a child and support the ongoing foster care placement and training programme if this remains in Lee's best interest. The conditions of Sex Offender Registration upon Lee's living arrangements and training programme must also be considered and should be informed by an assessment of whether such measures meet, reduce or increase the levels of risk and need in this instance. If Lee cannot remain in his foster placement (for example owing to conditions on Lee's contact with other children) there could be challenges accessing suitable accommodation as a consequence of his MAPPA status. Information sharing and discussions about the support they can provide with Lee's foster parents will be important. Child protection procedures could also have been considered at the time of the allegations for Lee and the two survivors/victims.

These would appear to be the most likely approaches adopted owing to Lee's age, conviction and legal status (both as a care leaver and as a registered sex offender).

There is no suggestion that Lee meets the criteria for ASP, therefore this is unlikely to be an option at this time. This could change, if further psychological or psychiatric concerns arise.

In line with Mental Health (Care and Treatment) (Scotland) Act 2003 legislation, an MHO could assess Lee's mental health needs and coordinate services if there are concerns about his mental state or risk to others. If Lee is found to have a mental disorder and poses a risk, a Compulsory Treatment Order could be considered. This allows for treatment in hospital or the community, even without consent. Lee may benefit from trauma-informed therapy, behavioural interventions, or psychological support as part of his rehabilitation, especially if minimisation of his actions suggests denial or cognitive distortions.

Whichever process is utilised, building a relationship with Lee and support to understand his perception of his offences, build his understanding of appropriate

behaviours in relationships, and the impact of sexual and physical harm will be important.

Harry: drug abuse and homelessness

Harry (17) lived with foster parents due to difficult relationships with his birth family. He has a mild learning difficulty, and his foster parents have previously commented on Harry's difficulty in expressing emotions, and dealing with stressful situations. However, following an argument he left his foster home and went to live with a distant cousin but this situation again broke down. Harry is now homeless and using heroin. He met his former teacher in the street and talked of ending his own life, and with cuts to his forearms visible. The teacher then made a referral to social work. He is vulnerable to involvement in offending, accidental overdose, the long term effects of his current situation and the risks of self-harm. He wants his own home, but is not sure how to achieve this.

Potential actions

Harry presents with a range of interrelated needs and presentations which can in practice make it difficult to ascertain which needs should be addressed as a priority, which service should assume lead responsibility, and there can be a lack of services where addiction and mental health is co-morbid. Harry is a child who practitioners report could easily become "lost in the system"- he is however at significant risk.

Harry already has a statutory entitlement to aftercare support owing to his status as a care leaver, which could provide an avenue to support for Harry-including post-18 if Harry's needs require this. With Harry's agreement, options for Harry to be voluntarily supported, including accommodated by the local authority, could be explored.

Due to risks associated with self-harm and drug use, Harry could be at risk of significant harm. Therefore, it would be possible to convene an IRD and thereafter consider a child protection investigation. Alternatively, it may be that Harry could be referred for a young people at risk multi-agency assessment or to equivalent processes dependant on the local area to address his needs. Attendance of adult services and/or an MHO at the IRD would be beneficial.

Harry could be referred to the Principal Reporter on the basis of his drug use and engaging in behaviours that could cause him harm.

If a Children's Hearing is convened, this could result in him being made subject to a Compulsory Supervision Order, perhaps back with his foster parents or in a kinship arrangement that could lead to stable accommodation, provision of advice and guidance that enables him to enjoy greater safety and coordination of the various supports that he requires. Consideration could be given to secure accommodation authorisation that if implemented by the Chief Social Work Officer would result in Harry being provided with intensive care, education and support within secure care (a locked facility).

Multi-disciplinary discussion with drug/alcohol recovery services, ASP and mental health services seems warranted (potentially via attendance at IRD if child protection procedures are utilised) and practitioners should ensure adult services are aware of Harry as he approaches 18. Housing support will be crucial and local opportunities

under housing protocols for care experienced children and young people should be explored-wherever possible. Harry should not need to go through a homeless route to access suitable accommodation. Harry is likely to require independent living support and this should be a core part of his child's plan. The Adults with Incapacity (Scotland) Act 2000 (AWI Act) could lead to a formal assessment of his capacity could be initiated if concerns over his substance misuse, emotional distress, and learning difficulty impair his ability to make safe decisions. If Harry lacks capacity to consent to medical treatment (e.g. for addiction or self-harm), a doctor may issue a Section 47 certificate allowing treatment in his best interests. If Harry is deemed incapable of managing his welfare or finances, a guardian (e.g. local authority) could be appointed to make decisions on his behalf. These measures must follow the principles of least restriction and benefit to the individual.

The Mental Health (Care and Treatment) (Scotland) Act 2003 could lead to Emergency Detention if Harry is at immediate risk (e.g. suicidal ideation, overdose). An Emergency Detention Certificate could result in Harry being detained in hospital for up to 72 hours for assessment. If this leads to further concerns, and if the threshold is met, a psychiatrist and MHO may authorise detention for up to 28 days for treatment and further evaluation. If ongoing treatment is needed and Harry refuses help, a Compulsory Treatment Order may be sought. This allows treatment in hospital or the community under legal conditions. These interventions must consider Harry's rights, wishes, and the least restrictive options.

An ASP referral could be considered. Harry is over 16; evidence of self-harm; evidence of suicidal ideation; but unclear based on brief description as to whether he meets ASP criteria.

Regardless of which approach is adopted, practitioners will require to manage a complex range of issues and a lack of scaffolding.

Saima: risk of suicide, and exploitation

Saima is 17 and lives with her older sister, with her parents both being dead. Over the past six months she has been returning home late, staying out all weekend and often appearing physically and emotionally drained. She has some bruising to her wrists, although refuses to say where they come from. She has attempted to end her life through suicide on two occasions over the past month by overdosing on painkillers, however doctors at the hospital do not believe she can be detained under Mental Health legislation. Her sister has found several mobile phones in her room, a bundle of money and cocaine wraps. Her sister believes she is being sexually exploited.

Potential actions

Given that Saima appears to be experiencing abuse, exploitation and at risk of significant harm, an IRD could be convened and child protection investigation initiated. Owing to the concerns for Samia's mental health and wellbeing and age, representatives from ASP/Adult Services should be involved in IRD or other case discussions. A contextual safeguarding approach may be helpful and specialist risk assessment tools to consider child sexual exploitation indicators and potential trafficking.

A referral could also be made under ASP. If those exploiting Saima are known - a Banning Order could be applied for (undue pressure would have to be evidenced if Samia was not in support of the Banning Order) - following an ASP multi-agency Case Conference (involving Samia and if appropriate, her sister) and ASP Protection Plan can be agreed.

Saima could be referred to SCRA due to concerns over her safety; she may be deemed to pose a risk to herself or at risk from third-parties. A hearing could consider whether she met the threshold for admission into secure care, or whether use of an MRC would be advantageous.

Post the Children (Care and Justice) Act commencing, the secure accommodation criteria will change to:

- (a) (i) that the child has previously absconded and is likely to abscond again unless the child is kept in secure accommodation, and,
 - (ii) if the child were to abscond, it is likely that the child's health, safety or development would be at risk;
- (b) That the child is likely to engage in self-harming conduct, unless the child is kept in secure accommodation;
- (c) That the child is likely to cause physical or psychological harm to another person unless the child is kept in secure accommodation.

All other options, including an MRC, will still require to be considered ahead of a secure accommodation authorisation being made.

Multi-disciplinary discussion with drug/alcohol recovery services as well as mental health services seems warranted. As well as a reminder that not meeting detention

criteria under mental health legislation on one occasion does not rule out its applicability in future. Saima should be kept under regular review and professionals alert to any change in circumstances that warrant re-referral or intervention.

Even if Child Protection processes are used, practitioners should ensure that Adult Services – especially adult mental health services – are aware of Samia as she approaches 18. A trauma informed approach is likely to be particularly important with Samia, as will efforts to build trusting relationships.

In the meantime, there are powers under the Adults with Incapacity (Scotland) Act 2000 that could be utilised. Saima's repeated suicide attempts, emotional withdrawal, and possible trauma may impair her ability to make safe decisions. A formal assessment of her decision-making capacity could be initiated. If Saima is deemed to lack capacity to consent to treatment (e.g. for trauma, addiction, or mental health), a doctor may issue a certificate allowing treatment in her best interests. If she cannot safeguard her own welfare, a court may appoint a welfare guardian (e.g. local authority) to make decisions about her care, accommodation, and protection. These actions must follow the principles of least restriction and benefit to the individual.

The Mental Health (Care and Treatment) (Scotland) Act 2003 may also offer options as to how best respond in this instance. If Saima is at immediate risk of suicide or serious harm, she may be detained in hospital for up to 72 hours for assessment as part of an Emergency Detention Certificate. If her condition warrants further evaluation, a psychiatrist and MHO may authorise detention for up to 28 days. If ongoing treatment is needed and Saima refuses help, a Compulsory Treatment Order may be sought to provide care in hospital or the community. These measures require medical and legal oversight and must respect her rights under the Act. Child and Adolescent Mental Health Services (CAMHS) is also available to all children and young people under the age of 18 years who present with clear symptoms of mental ill health which place them or others at risk and/or are having a significant and persistent impact on day-to-day functioning. The overwhelming majority of children open to CAMHS are not detained under the MHA and thus engagement on a voluntary basis is in keeping with the principles of the Act. CAMHS teams have access to a range of disciplines including nurse therapists. Saima may wish to consider support on a voluntary basis.

Whichever approach is adopted, this needs to be coupled with work to identify and target any individuals who are exploiting Saima.

Jason: mental health concerns and risk from others

Jason is 17 years old, lives independently, has never been on a CSO and experiences periods of psychosis. There is a family history of complex mental health issues, and Jason often uses a variety of illicit drugs. Last weekend he believed he was being attacked by passengers on a bus and used a knife to stab an elderly woman. She is now in critical care; he is in court cells and bail is opposed. He has been telling staff in the cells that he needs to get out as he owes people money and they will come looking for him.

Potential actions

A range of alternatives to remand, including the suitability of Jason's home as a bail address, including with supervised or electronically monitored bail, or other potential placements should be considered. These assessments should be relayed to the court in a timely manner to inform decision making. If Jason is to be remanded, he will be committed to the local authority to be detained, either in secure care if the court requires this or to a suitable place of safety chosen by the local authority, which could include Jason returning home, residing with a family member or placement into residential or secure care (as per s.51(1) of the Criminal Procedure (Scotland) Act 1995). If Jason was remanded and placed in secure care he would require to be treated as a looked after child.

An emergency mental health assessment should be sought whilst Jason is in police custody from the police surgeon or health care professional, and his fitness to appear in court should also be considered. A medical practitioner may assess the appropriateness of an Emergency Detention Certificate under civil measures (MHA) or an approved medical practitioner (AMP) may be contacted to assess the appropriateness of a STDC. In both instances MHO input will be sought. Social work should liaise with the Procurator Fiscal and health professionals as Jason may require a period of hospital admission for assessment to determine if he is fit to appear at court and for treatment. Contingency provision should also be considered in the event of a delay in finding an appropriate hospital provision. Police officers, health care staff, lawyers and the Crown Office and Procurator Fiscal Service (COPFS) may request a mental health assessment when a child is in custody and has not appeared before the Court.

Based on nature of the crime, the outcome of a mental health assessment could have relevance to court processes even if he is assessed as fit to appear and significantly impact on disposals should he be found guilty including use of secure hospital, compulsion order and other measures.

The outcomes of this initial mental health assessment and Jason's first court appearance will significantly impact on the approach(es) adopted.

Information regarding his drug use, psychotic episodes, risk of harm to himself and others, and safeguarding issues in relation to debt should be explored to help determine how to proceed. This could lead to an IRD being convened and a subsequent Child Protection investigation. There is also a possibility that Jason has or is subject to criminal exploitation and at a minimum it is likely Jason will require

coordinated, multi-agency support under GIRFEC via a child's plan to balance his rights, needs and the potential risks to others. Given the presenting needs, it would be appropriate for adult services to be part of the IRD. Those working with Lee could use both the [Criminal Exploitation of Children Framework for Practice](#) and the [accompanying tool](#) to consider the information currently available, and determine what else is required. This could lead to a referral being made to SCRA for consideration of compulsory measures of supervision. A referral to SCRA can be made in relation to his risk to self and concerns for Jason's welfare, as well as his risk to others. Contextual safeguarding approaches may also be beneficial in this case to identify risks outwith the family home.

CARM approaches may also be suitable for Jason, if he is deemed to pose a significant risk of harm to others. CARM procedures could be employed in parallel to the court or health assessment process.

Representation from ASP/Adult Services should also be sought at this IRD, as ASP pathway may be preferable in some instances due risk of exploitation and financial abuse. Jason's statements about owing money and expecting people to come looking for him indicate possible exploitation or intimidation. ASP inquiries may support multi-agency risk discussions, although it is likely that children's legislation would be the primary framework. Dialogue between children's services and their adult services counterparts would also be required as Jason approaches his 18th birthday and planning for support and interventions post birthday are made.

If Jason is convicted of an offence at court and is considered by the responsible authorities (police, health or the local authority) to pose a risk of serious harm to the public, he could be made subject to MAPPA under the Other Risk of Serious Harm category.

The Adults with Incapacity (Scotland) Act 2000 could be utilised, with Jason's psychosis and erratic behaviour possibly indicating that his ability to understand legal proceedings or make informed decisions is impaired. A formal assessment of his capacity could be initiated. If Jason is found to lack capacity, a guardian (e.g. local authority) could be appointed to make decisions about his welfare, treatment, and legal matters. Even if Jason retains partial capacity, the Act encourages support to help him participate in decisions about his care and legal situation.

The Mental Health (Care and Treatment) (Scotland) Act 2003 may also be beneficial if Jason is deemed an immediate risk to himself or others, with psychosis suggesting evidence of mental disorder. In such instances an Emergency Detention Certificate could be utilised that would lead to him being detained in hospital for up to 72 hours for assessment. A psychiatrist and MHO may authorise detention for up to 28 days for further evaluation and treatment. If Jason requires ongoing treatment and refuses help, a Compulsory Treatment Order may be imposed, allowing treatment in hospital or the community under legal conditions. These measures could ensure Jason receives psychiatric assessment and treatment, and provide a lawful means to manage risks to himself and others.

Regardless of which approach is used, a focus must be on addressing the underlying risks and vulnerabilities that result in him being exposed to harm.

Declan: criminal exploitation

Declan is 16 years old and lives with his parents. He was previously on a CSO during his early childhood due to concerns over parental substance abuse however these concerns dissipated around the age of 10. In the past few months, he has been spending extended periods of time in the company of older males who often drop him off late at night, and whom he refuses to speak about. He is reluctant to tell his parents where he has been or provide further details of what he had been doing with his time. His parents are worried that he is involved in drug dealing in some way due to him leaving the house late at night, appearing to have money that is unaccounted for and hearing rumours from an older sister that Declan has been moving drugs around the city via taxis. Declan denies all of this, although admits to making money through 'doing wee jobs' for friends from college.

Potential actions

Those working with Declan could use both the [Criminal Exploitation of Children Framework for Practice](#) and the [accompanying tool](#) to consider the information currently available, and determine what else is required. This could lead to a referral being made to the SCRA for consideration of compulsory measures of supervision.

If Declan was to be charged with an offence related to Criminal Exploitation of Children (CEC) those supporting him should consider whether the [Human Trafficking and Exploitation \(Scotland\) Act 2015](#) is relevant, with regards to the non-prosecution of victims of exploitation. It will be important that the multi-agency team around Declan recognise and understand that he is a victim. Given potential concerns over trafficking and criminal exploitation, one possible action could be referral to the Home Office's National Referral Mechanism (NRM). The NRM is a framework for identifying and supporting adult and child victims of trafficking. Alongside child protection processes, a referral to the NRM could be considered to look into the safety of Declan. Children (defined as those under 18 in this instance) do not need to consent to a NRM referral, adults must provide consent. Referrals are often made by Police, particularly when they are the first agency to encounter the child during the course of their exploitation. However, decisions regarding NRM referrals can also be made during the IRD meetings. Although NRM referrals are not mandatory, they are considered good practice. They can also be beneficial in cases where charges are brought against the young person. The NRM [Toolkit for First Responders](#) created by [Migration Scotland](#) may be beneficial to practitioners.

An IRD could be convened and child protection measures followed, which could involve adult services, given the potential risk of significant harm to Declan from exploitation. Practitioners should adopt a Contextual Safeguarding approach to respond to the risks situated within the community, which may involve sharing information and work with a range of wider partners e.g. taxi companies, fast food outlets, and transport police.

Whilst efforts would be made to work with Declan and his parents on a voluntary basis, consideration could be made of referring to SCRA if the referral criteria are met.

Concerns over Declan's capacity to make decisions due to trauma, coercion or development could lead to an assessment of capacity being undertaken under the Adults with Incapacity (Scotland) Act 2000. If this formal assessment results in lack capacity to safeguard his welfare or manage finances, a guardian (e.g. local authority) could be appointed to make decisions on his behalf. Even if Declan retains capacity, the Act encourages support to help him make informed choices and reduce risk. However, capacity must be assessed specifically for each decision, and suspicion of exploitation alone does not imply incapacity.

There are no indicators of mental ill health at this time, and so treatment through the Mental Health (Care and Treatment) (Scotland) Act 2003 is not appropriate.

Declan does not appear to meet the criteria for ASP, therefore it is unlikely that this would be considered at this time.

Whichever approach is taken, a principal focus should be on ensuring that he is safe and developing a trusting, meaningful relationship.

ⁱ Some areas have also developed processes that extend to children under and over 18, that cover risk of harm to self and others termed Vulnerable Young Person's protocols (or equivalent).